1 - 2 WEEK OLD WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. : (Medicaid/Ins)	Physician: ID #:	Actual age:

KEY: Mark NL if normal, Ab if abnormal, or Y if yes, N if no, or ✓, if item done

(1) HISTORY

1. General health	Nl	Ab
2. Delivery record in chart	Y	N
3. Hearing	Nl	Ab
4. Vision	Nl	Ab
5. Stools	Nl	Ab
6. Urine stream	Nl	Ab
7. Sleeping patterns	Nl	Ab
8. Crying	Nl	Ab
9. Skin problems	Y	N
10. Breast feeding q ___hrs	Nl	Ab
11. Formula _____		
12. Vitamins/Supplement		
13. Health/emot. status mother	Y	N
14. Family status Mo/fa sibs other	Nl	Ab
15. Prenatal health	Nl	Ab
16. Heat source	Nl	Ab
17. Smoke free environment	Y	N

(5) DEVELOPMENTAL MILESTONES

	Y	N
44. Response to sounds		
45. Fixates on face		
46. Follows with eyes		
47. Responds to parent's face, etc.		
48. Flexed posture		
49. Moves all extremities		

(2) PHYSICAL EXAM

	Nl	Ab
18. WT _____, _____ %		
19. HT _____, _____ %		
20. WT/HT _____ %		
21. HC _____, _____ %		
22. Skin (cradle cap, diaper derm.)		
23. Head fontanel		
24. Eyes (dacrostenosis, strabismus)		
25. Red reflex		
26. Ears/hearing		
27. Nose		
28. Throat (thrush)		
29. Neck/nodes		
30. Lungs		
31. Heart (murmurs), femoral pulses		
32. Abd (masses)		
33. Hernia		
34. Umbilicus		
35. Genitalia		
36. Circumcision		
37. Hips (dysplasia)		
38. Neuro (Moro)		
39. Extremities		
40. Dysmorphology		

(4) SCREENING

	Nl	Ab
43. Metabolic (hemoglobinopathy)		

(3) IMMUNIZATIONS GIVEN

	Y	N
41. Received Hep B# 1 in hospital		
42. If No, Hep B #1given today		
Other _____		

(6) KEY ANTICIPATORY GUIDANCE

✓	* = key items
	*50. Infant car seats in back
	*51. Sleeping position (back)
	*52. Teach early signs of illness: fever, fails to eat, trouble breathing, lethargy.
	*53. Keep home/car smoke free
	*54. Smoke detectors
	*55. Don't shake new baby
	56. Child care plans
	57. Test water temp. Keep below 120 F.
	58. Crib safety
	59. Supervise child at all times
	60. Discuss emergency protocol, 911
	61. Discuss infant care: cord care, circumcision care, sleep patterns, bowel movements, skin/nail care, colic/crying, thermometer use, etc.
	62. Breast feeding
	63. Iron fortified formula
	64. Avoid honey to 12 months
	65. Avoid bottle propping
	66. Sibling attention
	67. Time for mother and couple.
	68. Anticipate feeling tired, depressed, etc.
	69. Ask about Medicaid/WIC

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN	EPSDT only: Child needs assistance for follow up for testing/treatment	Y	N

PHYSICIAN SIGNATURE: _____ RTC in _____ months DATE: ___/___/___

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1 MONTH OLD WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID #:	Actual age:

KEY: Mark **NL** if normal, **Ab** if abnormal, or **Y** if yes, **N** if no, or ✓, if item done

(1) HISTORY

1. General health	Nl	Ab
2. Development	Y	N
3. Hearing	Nl	Ab
4. Vision	Nl	Ab
5. Stools	Nl	Ab
6. Urine	Nl	Ab
7. Sleeping patterns	Nl	Ab
8. Crying	Nl	Ab
9. Breast feeding q __hrs	Nl	Ab
10. Formula _____	Nl	Ab
11. Vitamins	Y	N
12. Health/emot. status of mother	Nl	Ab
13. Family status	Nl	Ab
14. Heat source	Nl	Ab
15. Smoke Free environment	Y	N

(5) DEVELOPMENTAL MILESTONES

	Y	N
41. Response to sounds		
42. Fixates on face		
43. Follows with eyes		
44. Can lift head briefly when prone		
45. Flexed posture		
46. Moves all extremities		
47. Palmar grasp		

(2) PHYSICAL EXAM

	Nl	Ab
16. WT _____,_____ %		
17. HT _____,_____ %		
18. WT/HT _____ %		
19. HC _____, _____ %		
20. Skin (cradle cap, diaper derm.)		
21. Head fontanel		
22. Eyes (dacrostenosis)		
23. Red reflex		
24. Ears		
25. Hearing		
26. Nose		
27. Throat (thrush)		
28. Neck		
29. Lungs		
30. Heart (murmurs), femoral pulses		
31. Abd (masses)		
32. Genitalia		
33. Hips (dysplasia)		
34. Neuro		
35. Extremities		
36. General hygiene		
37. Dysmorphology		

(4) SCREENING

	Nl	Ab
40. Assess for high risk lead (no renovation)		

(3) IMMUNIZATIONS GIVEN

	Y	N
38. If Hep B #1 not given yet, give today		
39. Other _____		

(6) KEY ANTICIPATORY GUIDANCE

✓	* = key items
	*48. Infant car seats in back
	*49. Test/lower water temp. below 120 F
	*50. Keep small or sharp objects away
	*51. Delay solids until 4-6 months
	*52. Daycare/childcare issues
	*53. Smoke detector
	54. Crib safety
	*55. Sleeping position (back)
	*56. Keep home/car smoke free
	57. No drinking hot liquids while holding baby
	58. Review early symptoms of illness
	59. Sun overexposure/sunscreen
	60. Review emergency protocol, 911
	61. Iron fortified formula
	62. Avoid microwaving formula
	63. Avoid honey to 12 months
	64. Avoid bottle propping
	65. Avoid putting to bed with bottle
	66. Infant care: cord care, circumcision care, sleep patterns, bowel movements, skin/nail care, colic/crying, thermometer use, etc
	67. Time for mother and couple
	68. Ask about Medicaid/WIC

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN	EPSDT only: Child needs assistance for follow up for testing/treatment	Y	N

PHYSICIAN SIGNATURE: _____ **RTC in** _____ **months** **DATE:** ___/___/___

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2 MONTH OLD WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D.#: (Medicaid/Ins)	Physician: ID #:	Actual Age: _____months _____weeks

KEY: Mark NL if normal, Ab if abnormal, or Y if yes, N if no, or ✓, if item done

(1) HISTORY

1. General health	Nl	Ab
2. Development	Nl	Ab
3. Hearing	Nl	Ab
4. Vision	Nl	Ab
5. Stools	Nl	Ab
6. Sleeping	Nl	Ab
7. Breast feeding q _____ hrs	Nl	Ab
8. Formula _____		
9. Feeding problems	Y	N
10. Vitamins/Supplements/Fe	Y	N
11. Health/emot. status of mother	Nl	Ab
12. Family status	Nl	Ab
13. Child care	Y	N
14. Smoke free environment	Y	N

(5) DEVELOPMENTAL MILESTONES

	Y	N
46. Coos, vocalizes reciprocally		
47. Attentive to voices		
48. Interest in sight/sound stimuli		
49. Eyes cross mid-line		
50. Smiles responsively		
51. Able to lift head, neck, chest		
52. Hands open at rest		
53. Control of head when upright		
54. Stops crying when spoken to		
55. Grasps rattle when placed in hand		

(2) PHYSICAL EXAM

	Nl	Ab
15. WT _____, _____ %		
16. HT _____, _____ %		
17. WT/HT _____ %		
18. HC _____, _____ %		
19. Skin		
20. Head, fontanel		
21. Eyes (strabismus)		
22. Red reflex		
23. Ears		
24. Hearing		
25. Nose		
26. Throat		
27. Neck (torticollis)		
28. Lungs		
29. Heart (murmurs), pulses		
30 Abd. (masses, umb., hernia)		
31. Genitalia		
32. Hips (dysplasia)		
33. Neuro		
34. Extremities (metatarsus adductus)		
35. Dysmorphology		
36. General hygiene		

(4) SCREENING

45. Test fluoride in water source		

(3) IMMUNIZATIONS GIVEN

	Y	N
37 HIB # 1 vaccine		
38. DTP/DtaP # 1		
39. Hib-DTP combined # 1		
40. OPV # 1		
41. IPV # 1		
42. Hep B # 2		
43. Other: _____		
44. Describe side effects & when to call		

(6) KEY ANTICIPATORY GUIDANCE

✓	(*) = key items
	*56. Infant car seats in back.
	*57. Sleeping position (back)
	*58. Keep home/car smoke free
	*59. Review early signs of illness
	*60. Daycare/childcare
	61. Smoke detectors
	62. Crib safety
	63. Lower water temp. below 120 F
	64. Sun exposure/sunscreen
	65. Infant care discussed: skin/nail care, colic/crying, sleep pattern, bowel movements, use of thermometer, pacifier, gum care, etc.
	66. No bottle in bed/crib
	67. Review emergency protocol, 911
	68. Breast feeding (consider 400 IU Vit. D/day)
	69. Delay solids to 4 - 6 months
	70. Age appropriate toys
	71. Baby-sitter use/safety
	72. Ask about Medicaid/WIC

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN	EPSDT only: Child needs assistance for follow up for testing/treatment	Y	N

PHYSICIAN SIGNATURE: _____ RTC IN _____ MONTHS DATE: ___/___/___

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4 MONTH WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID #:	Actual Age: _____Months_____Weeks

KEY: Mark **Nl** if normal, **Ab** if abnormal, or **Y** if yes, **N** if no, or ✓ , if item done

(1) HISTORY

	Nl	Ab
1. General health	Nl	Ab
2. Development	Nl	Ab
3. Hearing	Nl	Ab
4. Vision, eyes straight	Nl	Ab
5. Stools	Nl	Ab
6. Sleeping patterns	Nl	Ab
7. Immunization reactions	Y	N
8. Breast feeding q _____ hrs	Nl	Ab
9. Formula _____	Nl	Ab
10. Feeding problems	Y	N
11. Solids	Y	N
12. Health/emot. status of mother	Nl	Ab
13. Family status	Nl	Ab
14. Smoke free environment	Y	N
15. Child care plans	Y	N

(5) DEVELOPMENTAL MILESTONES

	Y	N
49. Babbles, coos		
50. Recognize parent's voice, etc.		
51. Smile, laughs, squeals		
52. Eyes follow 180°		
53. When prone, can lift head, etc.		
54. Rolls over (back to front)		
55. Controls head while sitting		
56. Pulls to sit/no head lag		

(2) PHYSICAL EXAM

	Nl	Ab
16. WT _____, _____%		
17. HT _____, _____%		
18. WT/HT _____%		
19. HC _____, _____%		
20. Skin		
21. Head, fontanel		
22. Eyes		
23. Red reflex		
24. Ears		
25. Hearing		
26. Nose		
27. Throat		
28. Teeth		
29. Neck		
30. Lungs		
31. Heart (murmurs), pulses		
32. Abdomen		
33. Genitalia		
34. Hernias		
35. Hips (dysplasia)		
36. Musc/Skel		
37. Neuro (reflexes)		
38. Extremities		
39. Dysmorphology		
40. General hygiene		

(4) SCREENINGS

48. Test fluoride in water source		

(3) IMMUNIZATIONS GIVEN

	Y	N
41. Hib # 2		
42. DTP/DtaP # 2		
43. OPV # 2		
44. IPV # 2		
45. Hep B # 2 (if not given at 2 mos)		
46. Other _____		
47. Describe side effects/when to call		

(6) KEY ANTICIPATORY GUIDANCE

✓	* = key items
	*57. Child proof home, all poisons locked
	*58. Poison control #
	*59. Introduce solids/pureed foods, gradually
	60. Infant car seats in back
	61. Smoke detectors
	62. Lower water temp. below 120 F
	63. Crib safety
	64. Sun exposure/sunscreen
	65. Sleeping position (back)
	66. Never leave baby unsupervised
	67. Toy safety (avoid balloons)
	68. Avoid infant walkers at any age
	69. Review early signs of illness
	70. Breastfeeding (consider Iron supps, Vit D)
	71. Avoid honey to 12 months
	72. Oral hygiene
	73. Keep small/sharp objects away
	74. Play with baby
	75. Bedtime routine/to bed awake
	76. Ask about Medicaid/WIC

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN	EPSDT only: Child needs assistance for follow up for testing/treatment	Y	N

PHYSICIAN SIGNATURE: _____ RTC in _____ months DATE: ___/___/___

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6 MONTH WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID #:	Actual Age:_____Month_____Weeks

KEY: Mark Nl if normal, Ab if abnormal, or Y if yes, N if no, or ✓, if item done

(1) HISTORY

1. General health	Nl	Ab
2. Development	Nl	Ab
3. Hearing	Nl	Ab
4. Vision, eyes straight	Nl	Ab
5. Stools/urine	Nl	Ab
6. Sleeping patterns	Nl	Ab
7. Breast feeding	Nl	Ab
8. Formula _____	Nl	Ab
9. Eating solids	Y	N
10. Vitamins	Y	N
11. Fluoride--consider based on water source test (water/Rx)	Y	N
12. Childcare/Daycare	Y	N
13. Family status	Nl	Ab
14. Smoke free environment	Y	N
15. Child care plans	Y	N

(5) DEVELOPMENTAL MILESTONES

	Y	N
49. Vocalizes single consonants		
50. Smiles, laughs, imitates		
51. Turns to sound		
52. Sits with support		
53. Rakes in small objects		
54. Grasps and mouths objects		
55. Transfers objects hand to hand		
56. Starts to self-feed		

(2) PHYSICAL EXAM

	Nl	Ab
16. WT _____ __, _____ %		
17. HT _____, _____ %		
18. WT/HT _____ %		
19. HC _____ __, _____ %		
20. Skin		
21. Head, fontanel		
22. Eyes, sym. light reflex		
23. Red reflex		
24. Eyes, cover-uncover		
25. Ears		
26. Hearing		
27. Nose		
28. Throat		
29. Teeth		
30. Neck		
31. Lungs		
32. Heart (murmurs), pulses		
33. Abdomen		
34. Genitalia		
35. Hips (dysplasia)		
36. Musculoskeletal		
37. Neuro		
38. Extremities		
39. General hygiene		

(4) SCREENING

47. Anemia -- if high risk	Y	N
48. Result CBC	Nl	Ab

(3) IMMUNIZATIONS GIVEN

	Y	N
40. HiB # 3		
41. DTP/DtaP # 3		
42. HiB-DTP combined		
43. OPV # 3		
44. IPV # 3		
45. Hep B # 3 (at least 4 mos after # 2)		
46. Other _____		

(6) KEY ANTICIPATORY GUIDANCE

√	* = key items
	* 57. Child proof home: poisons, matches, meds, alcohol, outlets, stairway gates, window guards, firearm storage
	* 58. Stranger fears, shyness
	59. Infant child seat in back
	60. Keep home, car smoke free
	61. Toy safety (avoid balloons)
	62. Avoid infant walkers at any age
	63. Ipecac, Poison Control #
	64. Introduce solids gradually
	65. Avoid choking/risk foods
	66. Always supervise eating
	67. Breastfeeding (consider Iron supps, Vit D)
	68. Limit juices
	69. Introduce a cup
	70. Clean teeth with soft toothbrush minimal or no toothpaste
	71. Teething
	72 Play social games, peek-a-boo
	73. Establish bedtime routines, to bed awake
	74. Read to baby everyday

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN	EPSDT only: Child needs assistance for follow up for testing/treatment	Y	N

PHYSICIAN SIGNATURE: _____ RTC in _____ months DATE: ___/___/___

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9 MONTH WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID #:	Actual Age:_____months_____weeks

KEY: Mark Nl if normal, Ab if abnormal, or Y if yes, N if no, or ✓, if item done

(1) HISTORY

1. General health	Nl	Ab
2. Development	Nl	Ab
3. Injuries	Y	N
4. Stools	Nl	Ab
5. Sleeping patterns	Nl	Ab
6. Breast feeding	Nl	Ab
7. Formula _____	Nl	Ab
8. Solids	Nl	Ab
9. Finger foods	Y	N
10. Feeding problems	Nl	Ab
11. Fluoride (water/Rx)	Y	N
12. Family status	Nl	Ab
13. Smoke free environment	Y	N
14. Child care plans	Y	N

(2) PHYSICAL EXAM

15. WT _____, _____ %		
16. HT _____, _____ %		
17. WT/HT _____ %		
18. HC _____, _____ %		
19. Skin		
20. Head, fontanel		
21. Eyes, (strabismus)		
22. Eyes, red reflex		
23. Ears		
24. Hearing		
25. Throat		
26. Teeth		
27. Lungs		
28. Heart (murmurs), pulses		
29. Abdomen		
30. Genitalia		
31. Testes (descended)		
32. Hips (dysplasia)		
33. Musculoskeletal		
34. Neuro (parachute reflex)		
35. Extremities		
36. General hygiene		

(3) IMMUNIZATIONS GIVEN

37. Hep B # 3 if not given at 6 mos		
38. Other _____		

(4) SCREENING

39. Anemia, CBC/Hgb/HCT	Y	N
40. Result CBC	Nl	Ab

(5) DEVELOPMENTAL MILESTONES

	Y	N
41. Babbles, imitates		
42. May say Mama, Dada		
43. Responds to name		
44. Understands "no"		
45. Crawls, creeps, scoots		
46. Sits independently		
47. Pulls to stand		
48. Pincer grasp		
49. Transfers block hand to hand		
50. Looks for fallen objects		
51. Shakes, bangs, throws objects		
52. Peek-a-boo		
53. Stranger anxiety		
54. Starts cup use		
55 .Usually sleeps all night		

(6) KEY ANTICIPATORY GUIDANCE

✓	* = key items
	* 56. Never leave baby unattended
	* 57. Choking, avoid risk foods
	* 58. Keep home/car smoke free
	59. Lower crib mattress
	60. Infant child seat in back
	61. Smoke detectors
	62. Toy safety (avoid balloons)
	63. Empty buckets, tubs, small pools of water
	64. Poisons locked
	65. Child proof home: poisons, matches, meds, alcohol, outlets, stairway gates, window guards
	66. Avoid guns or store safely
	67. Sun exposure/sunscreen
	68. Ipecac, Poison Control #
	69. Try table foods, finger foods
	70. Whole milk delayed until 12 months
	71. Continue iron supplement formulas
	72. Avoid bottle propping, in crib
	73. Wean from bottle/start cup use
	74. Brush teeth, minimal toothpaste
	75. Establish bedtime routine, to bed awake
	76. Setting limits
	77. Discuss child care arrangements
	78. Ask about Medicaid/WIC

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN	EPSDT only: Child needs assistance for follow up for testing/treatment	Y	N

PHYSICIAN SIGNATURE: _____ RTC in _____ months DATE: ___/___/___

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1 YEAR WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: **(Medicaid/Ins)**	**Physician:** **ID #:**	**Actual Age: _____Months**

KEY: Mark **Nl** if normal, **Ab** if abnormal, or **Y** if yes, **N** if no, or ✓ , if item done

(1) HISTORY

1. General health	Nl	Ab
2. Illnesses/injuries	Nl	Ab
3. Stools/urine	Nl	Ab
4. Sleeping	Nl	Ab
5. Feeding problems	Y	N
breastfeeding _____ x/day		
milk _____ oz/day		
meals _____ x/day		
wean to a cup		
6. Vitamins	Nl	Ab
7. Fluoride (water, Rx)	Y	N
8. Heat source	Y	N
9. Family nutrition, balanced	Nl	Ab
10. Diet	Nl	Ab
11. Family status	Nl	Ab
12. Smoke free environment	Y	N
13. Child care plans	Y	N

(5) DEVELOPMENTAL MILESTONES

	Y	N
48. Vocabulary 1 - 3 + words		
49. Pull to stand/cruises		
50. Stands alone (2-3 seconds)		
51. Walks		
52. Precise pincer grasp		
53. Points with index finger		
54. Bangs two blocks together		
55. Looks for dropped/hidden items		
56. Feeds self		
57. Drinks from a cup		
58. Waves bye-bye		
59. Understands "no"		
60. Play social games, peek-a-boo		

(2) PHYSICAL EXAM

	Nl	Ab
14 WT _____, _____%		
15. HT _____, _____%		
16. WT/HT _____%		
17. HC _____, _____%		
18. Skin		
19. Head, fontanel		
20. Eyes, sym. light reflex		
21. Eyes, red reflex		
22. Cover/uncover test		
23. Ears [TM]		
24. Hearing		
25. Throat		
26. Teeth (caries, bbtd)		
27. Neck		
28. Lungs		
29. Heart (murmurs), pulses		
30. Abdomen		
31. Genitalia		
32. Hips (dysplasia)		
33. Gait		
34. Musc/Skel		
35. Neuro		
36. Extremities		
37. General hygiene		

(4) SCREENING

45. Anemia-CBC/Hgb	Y	N
Results	Nl	Ab
46. Blood lead test if on Medicaid, WIC, etc. or at risk:		
• lives in pre-1960 housing	Y	N
• lives in pre-1978 housing with renovations within 6 months	Y	N
• lead poisoned sibling/playmate	Y	N
47. Do PPD (if Exposure risk)	Y	N
If done, result	Neg	Pos

(3) IMMUNIZATIONS GIVEN

	Y	N
38. Hib # 3 or # 4		
39. Hep B # 3 if not given already		
40. MMR # 1 (at 12 or 15 months)		
41. Varicella		
42. DTaP/DTP (if > 6 mos since # 3)		
43 Other _____		
44. Up to date?		

(6) KEY ANTICIPATORY GUIDANCE

√	* = key items
	* 61. Supervise constantly near hazards
	* 62. Switch to whole milk
	* 63. Child proof home: poisons, matches, meds, alcohol, outlets, stairway gates, window guards
	* 64. Switch to toddler car seat in back
	65. Lower crib mattress
	66. Test smoke detectors
	67. Keep home/car smoke free
	68. Avoid balloons/small objects
	69. Ensure water/playground safety
	70. Sun exposure/sunscreen
	71. Ipecac, Poison Control #
	72. CPR training
	73. Avoid mealtime battles
	74. Avoid choking, etc.
	75. Brush teeth, etc.
	76. Set limits, limit # of rules, be consistent
	77. Keep bedtime routines
	78. Praise good behavior
	79. Encourage reading, singing, talking
	80. Childcare/Daycare
	81. Ask about Medicaid/WIC

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN	EPSDT only: Child needs assistance for follow up for testing/treatment	Y	N

PHYSICIAN SIGNATURE: _____ **RTC in** _____ **months** **DATE:** ___/___/___

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15 MONTH WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID #:	Actual Age: _____Months

KEY: Mark **Nl** if normal, **Ab** if abnormal, or **Y** if yes, **N** if no, or ✓, if item done

(1) HISTORY

	Nl	Ab
1. General health		
2. Illnesses/Injuries		
3. Stools/urine		
4. Diet		
5. Feeding problems		
breastfeeding _____ x/day		
milk _____ oz/day		
meals _____ x/day		
wean to a cup		
6. Vitamins		
7. Fluoride (water, Rx)		
8. Family nutrition, balanced		
9. Family status		
10. Smoke free environment		
11. Child care plans		

(5) DEVELOPMENTAL MILESTONES

	Y	N
42. Vocabulary 3 - 6 + words		
43. Listens to story		
44. Points to one or more body parts		
45. Gestures what they want		
46. Understands simple commands		
47. Walks, stoops, climbs stairs		
48. Stacks blocks		
49. Feeds self with fingers		
50. Drinks from a cup		
51. Social play		

(2) PHYSICAL EXAM

	Nl	Ab
12. WT _____, _____%		
13. HT _____, _____%		
14. WT/HT_____ _____%		
15. HC _____, _____%		
16. Skin		
17. Head		
18. Eyes		
19. Hearing		
20. Ears [TM]		
21. Throat-nose		
22. Teeth (caries, bbtd)		
23. Neck		
24. Lungs		
25. Heart, pulses		
26. Abdomen		
27. Genitalia		
28. Musc/Skel		
29. Gait		
30. Neuro		
31. Extremities		
32. General hygiene		

(4) SCREENING

	Nl	Ab
40. Blood lead test (if not previously done)		
Blood lead test if on Medicaid,		
WIC, etc. or at risk:	Y	N
• lives in pre-1960 housing	Y	N
• lives in pre-1978 housing with renovations within 6 months	Y	N
• lead poisoned sibling/playmate	Y	N
41. Do PPD (if exposure risk)	Y	N
If done, result	Neg	Pos

(3) IMMUNIZATIONS GIVEN

	Y	N
33. HIB # 3 or # 4		
34. DTP/DtaP # 4		
35. Hep B # 3		
36. MMR		
37. Varicella		
38. Other _____		
39. Up to date?		

(6) KEY ANTICIPATORY GUIDANCE

√	* = key items
	*52. Supervise constantly near hazards
	*53. Offer variety of nutritious foods
	*54. Child proof home: poisons, matches, meds, alcohol, outlets, stairway gates, window guards
	55. Toddler car seat in back
	*56. Caution around animals
	57. Test smoke detectors
	58. Keep home/car smokefree
	59. Avoid balloons/small/sharp objects
	60. Ensure water/playground safety
	61. Sun exposure/sunscreen
	62. Ipecac, Poison Control #
	63. CPR training
	64. Encourage cup drinking
	65. Encourage self-feeding
	66. Avoid choking/risk foods
	67. Brush teeth will little or no toothpaste
	68. Keep bedtime routines
	69. Praise good behavior
	70. Read, sing, play together
	71. Stove/fireplace safety
	72. Childcare/Daycare
	73. No punitive toilet training

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN	EPSDT only: Child needs assistance for follow up for testing/treatment	Y	N

PHYSICIAN SIGNATURE: _____ RTC in _____ months DATE: ___/___/___

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18 MONTH WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID #:	Actual Age: _____Months

KEY: Mark **Nl** if normal, **Ab** if abnormal, or **Y** if yes, **N** if no, or ✓, if item done

(1) HISTORY

1. General health	Nl	Ab
2. Illnesses	Y	N
3. Sleeping/nap	Y	N
4. Feeding	Nl	Ab
breastfeeding _____ x/day	Y	N
milk _____ /day (24oz /day)		
5. Balanced diet	Y	N
6. Vitamins/supplements/Fe	Y	N
7. Fluoride	Y	N
8. Stools	Nl	Ab
9. Urine	Nl	Ab
10. Family status	Nl	Ab
11. Smoke free environment	Y	N
12. Child care plans	Y	N

(2) PHYSICAL EXAM

	Nl	Ab
13. WT _____, _____ %		
14. HT _____, _____ %		
15. HC _____, _____ %		
16. Skin		
17. Head, fontanel		
18. Eyes		
19. Hearing		
20. Ears [TM], Throat, Nose		
21 Teeth decay		
22. Neck		
23. Lungs		
24. Heart, pulses		
25. Abdomen		
26. Genitalia		
27. Musc/Skel		
28. Gait		
29. Neuro		
30. Extremities		
31. General hygiene		

(3) IMMUNIZATIONS GIVEN

	Y	N
if not done		
32. Hep B # 3		
33. Varicella		
34. IPV # 3		
35. OPV # 3		
36. DTaP , DTP # 4		
37. Up to date?		

(4) SCREENING

38. If no previous lead test done,	Y	N
Blood lead test if on Medicaid,		
WIC, etc., or at risk:	Y	N
• lives in pre-1960 housing	Y	N
• lives in pre-1978 housing with	Y	N
renovations within 6 months		
• lead poisoned sibling/playmate	Y	N
39. Do PPD (if exposure risk)	Y	N
If done, result	Neg	Pos

(5) DEVELOPMENTAL MILESTONES

	Y	N
40 Confident walk		
41. Walk backwards		
42. Throw ball		
43. Vocab 15-20 words		
44. Imitates words		
45. 2-word phrases		
46. Stacks 3 or 4 blocks		
47. Uses spoon and cup		
48. Shows affection		
49. Follows simple directions		
50. Scribbles		
51. Points to some body parts		
52. Can remove clothing		

(6) KEY ANTICIPATORY GUIDANCE

√	* = key items
	*53. Child oriented routines
	*54. Never leave child alone in car/home
	55. Smoke detectors
	56. Keep home/car smoke-free
	57. Toddler car seat in back
	58. Ensure water/playground safety
	59. Supervise constantly near hazards
	60. Cautions about pets
	61. Sun exposure/sunscreen
	62. Child proof home: poisons, matches, meds, alcohol, outlets, stairway gates, window guards
	63. Ipecac, Poison Control #
	64. Encourage self-feeding, cup use
	65. Avoid choking/risk foods
	66. Eat with family, highchair/booster
	67. Snacks low in sugar
	68. Continue teeth brushing
	69. Read, sing, talk with child
	70. Help them express feelings
	71. Model appropriate language
	72. Anger/temper tantrums
	73. Nightmares, night awakenings, fears
	74. Consistent limits/praise good behavior
	75. Ask about Medicaid/WIC

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN	EPSDT only: Child needs assistance for follow up for testing/treatment	Y	N

PHYSICIAN SIGNATURE: _____ **RTC in** _____ **months** **DATE:** ___/___/___

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2 YEAR OLD WELL CHILD EXAM

NAME:	VISIT DATE:___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID #:	Actual Age:_____Years_____Months

KEY: Mark Nl if normal, Ab if abnormal, or Y if yes, N if no, or ✓if item done

(1) HISTORY

	Nl	Ab
1. General health		
2. Illnesses/Injuries	Y	N
3. Off Bottle	Y	N
4. Feeding problems	Y	N
5. Vitamins	Y	N
6. Fluoride(water,/Rx)	Y	N
7. Family/Nutrition, balanced	Y	N
8. Diet_____	Y	N
9. Stools	Y	N
10. Urine	Nl	Ab
11. Family status	Nl	Ab
12. Heat source	Y	N
13. Smoke free environment	Y	N
14. Child care plans	Y	N

(2) PHYSICAL EXAM

	Nl	Ab
15. WT _____, _____%		
16. HT _____, _____%		
17. HC_____/_____%		
18. Skin		
19. Head		
20. Eyes		
21. Strabismus		
22. Ear [TM's], Nose, Throat		
23. Teeth (caries, BBTD)		
24. Neck		
25. Lungs		
26. Heart		
27. Abdomen		
28. Genitalia		
29. Gait		
30. Musc/Skel		
31. Neuro		
32. Extremities		
33. General Hygiene		

(3) IMMUNIZATIONS GIVEN

	Y	N
34. Up to date?		

if not, immun. given_____

(5) DEVELOPMENTAL MILESTONES

	Y	N
37. Walks up and down stairs		
38. Walks backwards		
39. Kicks a ball		
40. Stacks 5 or 6 blocks		
41. Vocab at least 20 words		
42. Knows name		
43. Draws a line		
44. Helps take off clothes		
45. Follows 2-step commands		
46. Points to 1 named body part		
47. Imitates housework		

(4) SCREENING

	Y	N
35. Anemia - CBC/Hgb results		
36. Lead poisoning - Blood lead test if:		
on Medicaid, WIC or	Y	N
• lives in pre-1960	Y	N
• lives in pre-1978 house		
renovations within 6 months	Y	N
• lead poisoned sibling/playmate	Y	N
Blood Test Result:_____	Nl	Ab

(6) KEY ANTICIPATORY GUIDANCE

✓	* = key items
	*48. Ensure water/playground safety
	*49. Avoid food eating struggles
	*50. Reinforce limits/ praise good behavior
	*51. Discuss community programs (preschool, Headstart, etc.)
	52. Test smoke detectors/change batteries
	53. Keep home/car smoke free
	54. Gun safety
	55. Ipecac, Poison Control #
	56. Childproof home - poisons, matches alcohol, outlets, etc
	57. Sun exposure/sunscreen
	58. Brush teeth with little or no toothpaste
	59. Encourage self care
	60. Anticipate genitalia curiosity
	61. Limit TV
	62. Promote toilet training when child ready
	63. Childcare arrangements
	64. Encourage reading

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN

EPSDT only: Child needs assistance for follow up for testing/treatment Y N

PHYSICIAN SIGNATURE: _____ **RTC in** _____ **months** **DATE:** ___/___/___

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3 YEAR OLD WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID #:	Actual Age:_____Years_____Months

KEY: Mark **Nl** if normal, **Ab** if abnormal, or **Y** if yes, **N** if no, or ✓if item done

(1) HISTORY

1. General health	Nl	Ab
2. Illnesses	Y	N
3. Injuries	Y	N
4. Vitamins	Y	N
5. Fluoride (water/Rx)	Y	N
6. Toilet trained	Y	N
7. Family/Nutrition, balanced	Nl	Ab
8. Stools	Nl	Ab
9. Urine	Nl	Ab
10. Family Status	Nl	Ab
11. Smoke free environment	Y	N
12. Child care plan	Y	N

(2) PHYSICAL EXAM

	Nl	Ab
13. WT _____, _____ %		
14. HT _____, _____ %		
15. Blood Pressure _____/_____		
16. Skin		
17. Head		
18. Eyes		
19. Visual accuity R20/___L20/___		
20. Ears, (TM's) nose, throat		
21. Teeth (caries, dental injuries)		
22. Neck		
23. Lungs		
24. Heart		
25. Abdomen		
26. Genitalia		
27. Musc/Skel		
28. Gait		
29. Neuro		
30. Extremities		
31. General hygiene		

(3) IMMUNIZATIONS GIVEN

	Y	N
32 Up to date?		
if not, immun. given_____		

(5) DEVELOPMENTAL MILESTONES

	Y	N
36. Jumps, kicks ball		
37. Balances on one foot		
38. Rides tricycle		
39. Knows 1 color		
40. Copies, circle, cross		
41. Can sing a song		
42. Knows name, age, sex		
43. Uses plurals; 3 & 4 word sentences		
44. Uses "I" & "Me"		
45. Follows 2-3 part commands		
46. Self care skills		
47. Dress self		
48. Able to share toys		
49. Play well with another child		

(4) SCREENING

33. Blood lead test (if high risk and not previously tested.	Nl	Ab
34. Assess risk hyperlipidemia	Nl	Ab
parents/grandparents hx CVD <55 yo	Nl	Ab
parents cholesterol ≥ 240 mg/dl	Nl	Ab
consider, if unknown hx and child hx	Nl	Ab
(obesity, HTN, tobacco use, DM, inactivity)	Nl	Ab
If abnormal do fasting lipid profile	Nl	Ab
35. Do PPD (if exposure risk)	Nl	Ab
If done , Result	Neg	Pos

(6) KEY ANTICIPATORY GUIDANCE

✓	* = key items
	*50. Brush teeth as parent & child team
	*51. Limit TV
	*52. Teach stranger safety
	*53. Dental referral
	54. Car seat in back
	55. Keep home/car smoke free
	56. Ensure playground/water safety
	57. Test smoke detectors/check batteries
	58. Sun exposure/sunscreen
	59. Childproof home (matches, poisons, meds, alcohol, outlets, guns, etc.)
	60. Ipecac, Poison Control #
	61. Provide healthy choices for snacks/meals
	62. Expect normal sexual curiosity
	63. Give individual attention; opportunities to explore, socialize, play
	64. Provide chores, enforce limits/ time outs
	65. Help siblings resolve arguments
	66. Set limits/praise good behavior
	67. Imaginary friends
	68. Encourage reading
	69. Serve as a role model for behavior & habits
	70. Refer Medicaid/WIC
	71. Discuss community programs (i.e Headstart)
	72. Childcare/daycare

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN

EPSDT only: Child needs assistance for follow up for testing/treatment Y N

PHYSICIAN SIGNATURE: _____ **RTC in** _____ **months** **DATE:** ___/___/___

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4 YEAR OLD WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID #:	Actual Age:_____Years_____Months

KEY: Mark Nl if normal, Ab if abnormal, or Y if yes, N if no, or ✓, if item done

(1) HISTORY

	Nl	Ab
1. General health		
2. Illnesses	Y	N
3. Injuries	Y	N
4. Vitamins	Y	N
5. Fluoride (water/Rx)	Y	N
6. Family nutrition, balanced diet	Nl	Ab
7. Stools	Nl	Ab
8. Urine, enuresis	Nl	Ab
9. Family Status	Nl	Ab
10. Smoke free environment	Y	N
11. Child care plans	Y	N

(2) PHYSICAL EXAM

	Nl	Ab
12. WT_____, _____%		
13. HT _____, _____%		
14. WT/HT _____%		
15. Blood pressure _____/_____		
16. Skin		
17. Head		
18. Eyes		
19. Ears, nose,throat		
20. Teeth (Caries, injuries)		
21. Neck		
22. Lungs		
23. Heart		
24. Abdomen		
25. Genitalia		
26. Musc/Skel		
27. Gait		
28. Neuro		
29. Extremities		
30. General hygiene		

(3) IMMUNIZATIONS GIVEN

	Y	N
31. OPV / IPV #4		
32. DPT / DTaP #5		
33. MMR #2		
34. Other_____		
35. Up to date?		

(4) SCREENING

36. Consider Vision - Tumbling E or HOTV preference R 20/____ L 20/____	Nl	Ab
37. Consider Hearing R_____ L_____	Nl	Ab
38. Assess risk hyperlipidemia (Consider Screening)	Nl	Ab
39. Do PPD (if Exposure risk)	Y	N
Result	Nl	Ab
40. Blood lead test (if high risk and not previously tested.	Nl	Ab

(5) DEVELOPMENTAL MILESTONES

	Y	N
41. Can sing a song		
42. Draws person with 3 parts		
43. Aware of gender		
44. Knows fantasy from reality		
45. Uses verbs/full sentences		
46. Gives first and last name		
47. Knows 3 or 4 colors		
48. Talks about day		
49. Buttons clothes		
50. Builds tower with 10 blocks		
51. Hops, jumps on one foot		
52. Rides with training wheels		
53. Throws ball overhead		
54. Puts toys away		

(6) KEY ANTICIPATORY GUIDANCE

✓	* = key items
	*55. Use Bike/ski helmets
	*56. Teach stranger safety
	*57. School Readiness
	58. Child car seat in back
	59. Test smoke detectors, change batteries
	60. Keep home/car smoke free
	61. Sun exposure/sunscreen
	62. Ensure water/playground safety
	63. Brush teeth 2X daily
	64. Dental apt.
	65. Expect sexual curiosity/use correct terms
	66. Set limits, praise good behavior
	67. Limit TV
	68. School readiness
	69. Enroll in school (preschool, etc.)
	70. Discuss afterschool child care
	71. Discuss community programs
	72. Encourage Reading

ASSESSMENT/ABNORMALS (Use reference numbers PLAN	EPSDT only: Child needs assistance for follow-up testing/treatment	Y	N

PHYSICIAN SIGNATURE:_____ RTC in _____ months DATE:_____

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5 YEAR OLD WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID #:	Actual Age:_____Years_____Months

KEY: Mark Nl if normal, Ab if abnormal, or Y if yes, N if no, or ✓, if item done

(1) HISTORY

		Nl	Ab
1.	General health		
2.	Illnesses	Y	N
3.	Accidents	Y	N
4.	Eating	Y	N
5.	Vitamins	Y	N
6.	Fluoride (water/Rx)	Nl	Ab
7.	Speech	Nl	Ab
8.	Peer/Social Adjustment	Nl	Ab
9.	Family nutrition	Nl	Ab
10.	Family status	Nl	Ab
11.	Parent/child interaction	Nl	Ab
12.	Smoke free environment	Y	N
13.	Child care plans		

(2) PHYSICAL EXAM

		Nl	Ab
14.	WT_____, _____ %		
15.	HT _____, _____ %		
16.	WT/HT _____ %		
17.	Blood pressure _____/_____		
18.	Skin		
19.	Ears [TMs] Noses, Throat		
20.	Visual Acuity R ___/___ L___/___		
21.	Hearing R _____ L_____		
22.	Teeth (caries, malocclusion)		
23.	Neck		
24.	Lungs		
26.	Abdomen		
27.	Genitalia		
28.	Musc/Skel		
29.	Neuro		
30.	Extremities		
31.	General hygiene		

(3) IMMUNIZATIONS GIVEN

		Y	N
32.	All up to date?		
33.	DTP #5		
34.	OPV #4		
35.	MMR #2		
36.	Other _____		

(4) SCREENING

		Nl	Ab
37.	Vision (20 ft) Tumbling E or HOTV preference		
38.	Hearing	Nl	Ab
39.	Assess risk hyperlipidemia	Nl	Ab
40.	Do PPD (if Exposure risk)	Y	N
	Result	Neg	Pos

(5) DEVELOPMENTAL MILESTONES

		Y	N
41.	Dresses self without help		
42.	Knows address/telephone number		
43.	Understands opposites		
44.	Can count on fingers		
45.	Copies triangle or square		
46.	Draw person with extremities		
47.	Recognizes most of alphabet		
48.	Knows colors		
49.	Prints some letters		
50.	Plays make-believe/dress up		
51.	May be able to skip		
52.	Heel to toe walk		

(6) KEY ANTICIPATORY GUIDANCE

✓	* = key items
	*53. Car seat in back/transition to seatbelt
	*54. Pedestrial playground safety
	*55. Discuss dental sealants
	*56. Praise and encourage child
	*57. Meet with teachers/program for school
	*58. Tour school with child
	*59. Test smoke detectors/change batteries
	*60. Keep home/care smoke free
	61. Safe after school environment
	62. Avoid/lock up guns safely
	63. Teach stranger safety
	64. Healthy choices for meals/snacks
	65. Brush teeth at least 2X daily
	66. Ensure adequate sleep/exercise
	67. Sun exposure/sunscreen
	68. Limit TV
	69. Teach about personal hygiene
	70. Expect sexual curiosity
	71. Give individual attention
	72. Set limits/praise good behavior
	73. Assign chores
	74. Encourage reading

ASSESSMENT/ABNORMALS (Use reference numbers PLAN	EPSDT only: Child needs assistance for follow-up testing/treatment	Y	N

PHYSICIAN SIGNATURE:_____ RTC in _____ months DATE:_____

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6 YEAR OLD WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID #:	Actual Age:_____Years_____Months

KEY: Mark Nl if normal, Ab if abnormal, or Y if yes, N if no, or ✓, if item done

(1) HISTORY

1. General health	Nl	Ab
2. Illnesses	Y	N
3. Injuries	Y	N
4. Diet/Eating habits	Y	N
5. Vitamins	Y	N
6. Fluoride (water/Rx)	Y	N
7. Stools/Urine	Y	N
8. Exercise	Y	N
9. Peer/Social adjustment	Y	N
10. Family status	Nl	Ab
11. Smoke free environment	Y	N
12. Child care plans	Y	N

(2) PHYSICAL EXAM

	Nl	Ab
13. WT_____,_____%		
14. HT_____,_____%		
15. WT/HT_____,_____%		
16. Blood pressure_____/_____		
17. Skin		
18. Ears (TM's), Nose, Throat		
19. Visual Acuity R 20/____L 20/____		
20. Hearing R_____L_____		
21. Teeth (caries, injury)		
22. Neck		
23. Lungs		
24. Heart		
25. Abdomen		
26. Genitalia		
27. Musc/Skel		
28. Neuro		
29. Extremities		
30. General Hygiene		

(3) IMMUNIZATIONS GIVEN

(If not done)		
31. DTP/DtaP #5	Y	N
32. MMR # 2	Y	N
33. OPV/IPV # 4	Y	N
34. Up to date?	Y	N
35. Other_____		

(5) DEVELOPMENTAL MILESTONES

38. Any concerns about child's development/behavior?	Y	N
39. Proud of personal achievements?	Y	N
40. Opinion concerning school progress.	Nl	Ab
41. How is attendance?	Nl	Ab
42. Review report card.	Y	N
43. Able to follow school rules?	Y	N
44. Plays well with peers?	Y	N
45. Do parents acknowledge/praise child's schoolwork?	Y	N
46. Child shares with parents about school?	Y	N
47. Teacher's comments during conference	Y	N

(4) SCREENING

36. Assess risk hyperlipidemia	Nl	Ab
37. Do PPD (If exposure risk) If done	Neg	Pos

(6) KEY ANTICIPATORY GUIDANCE

√	* = key items
	* 48. Use seat belt in back at all times
	* 49. Limit TV
	* 50. Use bike/helmet
	* 51. Encourage reading
	52. Keep car/home smoke-free
	53. Test smoke detectors/change batteries
	54. Ensure water/playground safety
	55. Pedestrian/playground safety
	56. Sun exposure/Sunscreen
	57. Safe afterschool environments
	58. Teach stranger safety
	59. Healthy meals/nutritious snacks
	60. Teach how to choose healthy snacks
	61. Brush teeth/appt.dentist/dental sealant
	62. Ensure adequate sleep/exercise
	63. Assign chores and provide personal space
	64. Set limits/praise good behavior

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN

EPSDT only: Child needs assistance for follow up testing/treatment Y N

PHYSICIAN SIGNATURE: _____ **RTC in** _____ **months** **DATE:** ___/___/___

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7/8 YEAR OLD WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID #:	Actual Age:_____Years_____Month

KEY: Mark Nl if normal, Ab if abnormal, or Y if yes, N if no, or ✓, if item done

(1) HISTORY

	Nl	Ab
1. General health		
2. Illnesses	Y	N
3. Injuries	Y	N
4. Diet	Y	N
5. Exercise	Nl	Ab
6. Stool, urine	Y	N
7. Sleeping	Nl	Ab
8. Peer/Social Adjustment	Nl	Ab
9. Family Status	Nl	Ab
10. Fluoride (water/Rx)	Y	N
11. Smoke free environment	Y	N

(2) PHYSICAL EXAM

	Nl	Ab
12. WT _____, _____%		
13. HT _____, _____%		
14. WT/HT _____%		
15. BP _____/_____		
16. Skin		
17. Ear (TM), Nose, Throat		
18. Vision R 20/____ L 20/____		
19. Hearing R_____ L_____		
20. Teeth (caries, injuries)		
21. Neck		
22. Lungs		
23. Heart		
24. Abdomen		
25. Genitalia (early puberty girls)		
26 Musc/Skel (scoliosis)		
27. Neuro.		
28. Extremities		
29. General Hygiene		

(3) IMMUNIZATIONS GIVEN

	Y	N
30. Up to date?		
Consider Hep B.		

(4) SCREENING

	Nl	Ab
31. Assess risk hyperlipidemia		
32. Do PPD (if exposure risk)		
If done, results:	Neg	Pos

(5) DEVELOPMENTAL MILESTONES

	Y	N
33. Review report card or IEP if special needs		
34. Concerns about schoolwork or behavior		
35. Reading at grade level?		
36. Math at grade level?		
37. In any special classes?		
38. Child proud of achievements?		
39. Teacher comments at conference		
40. Best friend_____		
41. Hobbies/Sports_____		

(6) KEY ANTICIPATORY GUIDANCE

✓	* = key items
	*42. Counsel about avoiding tobacco, etc.
	*43. Help child pursue talents
	*44. Seat belts in back
	45. Test smoke detectors/change batteries
	46. Keep home/car smoke free
	47. Bike/ski helmet
	48. Reinforce safety rules for emergencies, etc.
	49. Keep guns locked
	50. Teach about healthy snacks/meals
	51. Brush teeth, dental appt.
	52. Ensure adequate sleep, exercise, hygiene
	53. Learn dental emergency care
	54. Sexuality education (prepare for puberty)
	55. Reinforce limits/praise good behavior
	56. Monitor TV and music
	57. Encourage reading
	58. How to resolve conflicts, handle anger
	59. Assign chores
	60. Serve as a role model for behavior & habits
	61. Set reasonable but challenging goals
	62. Reexamine after-school care
	63. Extracurricular activities

ASSESSMENT/ABNORMAL (use reference numbers) PLAN	EPSDT only: Child Needs assistance for follow-up testing/treatment	Y	N

PHYSICIAN SIGNATURE:_____ _____ RTC in _____ months DATE_____

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9/10 YEAR OLD WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID #:	Actual Age:_____Years_____Months

KEY: Mark Nl if normal, Ab if abnormal, or Y if yes, N if no, or ✓, if item done

(1) HISTORY

1. General health	Nl	Ab
2. Illnesses	Y	N
3. Accidents	Y	N
4. Exercise	Y	N
5. Diet	Nl	Ab
6. Favorite foods	Y	N
7. Sleeping	Nl	Ab
8. Menses	Y	N
9. Peer/Social adjustment	Nl	Ab
10. Family Status	Nl	Ab
11. Family meals together	Y	N
12. Smoke free environment	Y	N
13. Child care plans		
14. Do both parent/child ask questions?	Y	N

(2) PHYSICAL EXAM

	Nl	Ab
15. WT_____, HT_____		
16. BMI_____%		
17. BP_____/_____		
18. Skin		
19. Ears		
20. Nose		
21. Throat		
22. Vision R20/____L20/____		
23. Hearing R_____L_____		
24. Teeth (Caries, injuries, etc)		
25. Neck		
26. Lungs		
27. Heart		
28. Abdomen		
29 Genitalia		
30 Tanner stage_____		
31. Musc/skel (scoliosis)		
32. Neuro		
33. Extremities		
34. General Hygiene		

(3) IMMUNIZATIONS GIVEN

	Y	N
35. Up to date? Consider Hep B		

(6) KEY ANTICIPATORY GUIDANCE

√	* = key items
	*53. Teach about healthy snacks/ meals
	*54. Counsel about avoiding tobacco and other drugs
	*55. Help child pursue talent
	*56. Bike & ski helmet
	57. Seat belts in back
	58. Test smoke detectors/change batteries
	59. Keep home/car smoke free
	60. Reinforce safety rules for emergencies
	61. Sun exposure/sunscreen
	62 Keep guns locked
	63. Brush teeth, floss. Dental appt, sealants
	64. Ensure adequate sleep, exercise, hygiene
	65. Sexuality education (prepare for puberty)
	66. Encourage reading & hobbies
	67. Reinforce limits & praise achievement
	68. Monitor TV & music
	69. How to resolve conflicts, handle anger
	70. Serve as role model for behavior & habits
	71. Set reasonable but challenging goals
	72. Reexamine after-school care

(5) DEVELOPMENTAL MILESTONES

38. Review report card or IEP	Y	N
39. Attendance?		
40. Reading at grade level?		
41. Math at grade level?		
42. Any special classes?		
43. Follows rules at school?		
44. Proud of school achievements?		
45. Parent visited classroom?		
46. Parent school participation?		
47. Child talk to parent about school		
48. Child identified any special interests/talents wanting to pursue?		
49. Opinions given by teacher?	Neg	Pos
50. Best friend_____		
51. Hobbies/sports_____		
52. Any specific concerns?		

(4) SCREENING

36. Assess Hyperlipidemia risk	Nl	Ab
37. Do PPD (if exposure risk) if done PPD	Neg	Pos

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN

EPSDT only: Child Needs Assistance for follow-up testing/treatment Y N

PHYSICIAN SIGNATURE: _____ **RTC in** _____ **months** **DATE:** ___/___/___

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EARLY ADOLESCENT (11-14 yo) WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID#:	Actual Age:

MARK UNDER APPROPRIATE ANSWER , KEY: Mark Nl for normal, Ab for abnormal, or Y for yes, N for No or ✓ if item done

(1) HISTORY

	Nl	Ab
1. General health		
2. Illnesses/Injuries_____	Y	N
3. Allergies_____	Y	N
4. Meds_____	Y	N
5. Exercise_____	Y	N
6. Sports_____	Y	N
7. Diet_____	Nl	Ab
8. Adequate Ca(2+) intake (females)	Y	N
9. Menses_____	Y	N
10. Family Hx of sudden death	Y	N
Family Hx of depression	Y	N
Other_____		
11. Parent/Adolescent Interaction	Nl	Ab
Does parent allow adolescent to be interviewed alone?	Y	N

(2) PHYSICAL EXAM

	Nl	Ab
12. WT_____ HT_____		
13. BMI _____%		
14. Skin (acne)		
15. Ear, nose, throat		
16. Teeth (caries, injury)		
17. Neck		
18. Lungs		
19. Heart		
20. Breasts (teach female self-exam)	Y	N
21. Abd (hernias)		
22. Genitalia		
23. Tanner stage_____		
24. Pelvic exam (if sexually active)		
25. Testicle (teach males self-exam)	Y	N
26. Musc/Skel (scoliosis)		
27. Neuro		
28. Extremities		
29. General hygiene		

(3) IMMUNIZATIONS GIVEN

	Y	N
30. Up to date?		
31. Hepatitis B virus #1, #2, #3	Y	N
32. MMR #2	Y	N
33. Td vaccine at 14-16 yo	Y	N

(5) DEVELOPMENTAL /SCHOOL PERFORMANCE

Social/Emotional Development:

41. Best friend_____
42. Activities for fun_____
43. Things good at_____
44. What worries you?_____
45. Feel sad or alone?_____

Family:

46. Who do you live with?_____
47. How is family relationship?_____
48. Do they listen to you?_____
49. How are you doing in school? (Nl / Ab)
50. How often are you absent?_____

Physical dev. & Health Hazards:

51. Feelings about your appearance?____
52. Average time watching TV, etc./wk____

53. Smoke	Y	N
54. Chew tobacco, cigars	Y	N
55. Drink alcohol	Y	N
56. Take drugs	Y	N
57. Feel peer pressure?_____ How do you handle this_____		
58. Started dating?	Y	N
59. Wet dreams? Started period? Regular?	Y	N
60. Any questions about sex?	Y	N
61. Are you having sex with men, women or both	Y	N
62. Use birth control/condoms?	Y	N

(6) KEY ANTICIPATORY GUIDANCE

✓	* = key items
	*63. Use seat belts
	64. Bike helmets/protective gear
	65. Test smoke detectors/change batteries
	66. Keep home/care smoke-free
	67. Sun exposure/sunscreen
	*68. Exercise 3X a week
	*69. Discuss proper athletic training
	*70. Confide in someone when stressed, etc.
	71. Limit high fat, high sugar snacks
	*72. Include iron in diet (ie. meat, greens)
	*73. Manage weight through proper diet & exercise
	*74. Brush teeth, see dentist, sealants, floss, mouth guard, safety
	*75. Sexuality education (safety, abstinence, ability to say 'no')
	76. Counsel about avoiding tobacco, alcohol, other substances
	*77. Gun/weapon safety
	*78. Spend quality time with family
	*79. Practice peer refusal skills
	80. Participate in social & Community activities

(4) SCREENING

34. Vision (if not done at school or problem)	Nl	Ab
35. Hearing (if problems occur)	Nl	Ab
36. PPD (if exposure risk)	Nl	Ab
If done , Result_____	Neg	Pos
37. Oral screening		

38. Annual Hct, Hgb (if heavy menses, extreme wt. loss, etc)	Y	N
Result_____	Nl	Ab
39. High risk hyperlipidemia(if risk)	Nl	Ab
Lipid result_____		

40. If sexually active:

PAP Smear____	Nl	Ab
Gonnorhea____	Neg	Pos
Chlamydia____	Neg	Pos

If at risk, consider syphylis (VDRL/RPR), HIV

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN	EPSDT Only: Child Needs assistance for follow-up testing/treatment	Y	N

PHYSICIANS SIGNATURE:_____ **DATE:**_____ **RTC in** _____ **months**

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MIDDLE ADOLESCENT (15, 16, & 17 year old) WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID#:	Actual Age:

MARK UNDER APPROPRIATE ANSWER , KEY: Mark Nl for normal, Ab for abnormal, or Y for yes, N for No, or ✓ if item done

(1) HISTORY

1. General health	Nl	Ab
2. Illnesses/Injuries_____	Y	N
3. Allergies_____	Y	N
4. Meds_____	Y	N
5. Exercise_____	Y	N
6. Diet_____	Nl	Ab
7. Work	Y	N
8. Driver's License	Y	N
9. Menses_____	Y	N
10. Future plans	Y	N
11. Family changes	Y	N
12 Parent/Adolescent Interaction	Nl	Ab
Able to interview adolescent alone	Y	N

(2) PHYSICAL EXAM

	Nl	Ab
13. WT_____ HT_____		
14. BMI _____%		
15. BP____/____		
16. Skin		
17. HEENT-Ear, nose, throat		
18. Teeth		
19. Neck		
20. Lungs		
21. Heart		
22. Breasts (Female-condyloma; makes gynecomastia)		
23. Testicles (teach males self-exam)		
24. Tanner stage _____		
25. Pelvic exam (if sexually active)		
PAP smear _____		
26. Musc/Skel (scoliosis)		
27. Neuro		
28. Extremities		
29. General hygiene		

(3) IMMUNIZATIONS GIVEN

30. Up to date?	Y	N
(HBV, MMR #2, Td 14-16 yo)	Y	N
31. If no, shots given _____	Y	N

(5) DEVELOPMENTAL /SCHOOL PERFORMANCE

Social/Emotional Development:

___40. What do you do for fun?

___41. Do you ever feel down or depressed?

___42. Who do you confide in with your feelings?

___43. Have friends/relatives tried suicide?

___44. Any thoughts of hurting yourself?

Physical:

___45. Feelings about your appearance?

___46. Do you smoke, drink, or use drugs?

___47. Do you own a gun?
Is one kept in the house?

School

___48. Is school work difficult for you?

___49. How often are you absent?

Sex:

___50. Do you date? Any steady partner?

___51. Any worries/questions about sex?

___52. Have you begun havings sex? If yes, kinds of birth control needed?

___53. Ever been touched uncomfortably

___54. Take drugs

(6) KEY ANTICIPATORY GUIDANCE

✓	* = key items
	*55.Use seat belts & follow speed limits
	56. Test smoke detectors/change batteries
	57. Bike helmets/protective gear used? Mouth guard safety
	58. Use sunscreens
	*59. Exercise 3X a week and limit TV
	*60. Assess conflict resolution skills
	*61. Sexuality education-safety
	*62. Counseling avoiding tobacco, alcohol, etc.
	*63. Gun/Weapon safety
	*64. Listen to trusted friends & adults
	65. Eat variety of healthy foods low in fat, high in calcium & iron
	*66. Brush teeth, see dentist, floss,
	*67. Ask questions about sex/STDs, etc.
	*68. Respect parents limit
	69. Practice peer refusal skills
	*70. Discuss frustrations with school & thoughts of dropping out
	*71. Discuss future plans (i.e. vocation , college)
	72. Students may be involved with sports

(4) SCREENING

32. Vision - if at risk	Nl	Ab	36. High risk hyperlipidemia (if risk)	Nl	Ab	38. Syphilis (VDRL/RPR), if at risk	Neg	Pos
33. Hearing -if at risk	Nl	Ab	Lipid result_____			39. HIV test, if at risk	Neg	Pos
34. PPD (if exposure risk)	Nl	Ab	37. STD screening, if sexually active	Neg	Pos			
If done , Result_____	Neg	Pos	Gonnorhea	Neg	Pos			
35. Annual Hct, HgbOral screening, if at risk Hct, Hgb results	Nl	Ab	Chlamydia	Neg	Pos			

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN	EPSDT Only: Child Needs Assistance for follow-up testing/treatment	Y	N

PHYSICIANS SIGNATURE:_____ DATE:_____ RTC in _____ months

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LATE ADOLESCENT (18, 19, 20 yo) WELL CHILD EXAM

NAME:	VISIT DATE: ___/___/___	DOB: ___/___/___
I.D. #: (Medicaid/Ins)	Physician: ID#:	Actual Age:_____Years_____Months

KEY: Mark Nl if normal, Ab if abnormal, or Y if yes, N if no, or ✓, if item done

(1) HISTORY

	Nl	Ab
1. General health		
2. Complaints		
3. Pertinent Ros		
4. Allergies		
5. Meds		
6. Significant PMH		
7. Family Hx Update		
8. Exercise		
9. School		
10. Job		
11. Menses Hx		
12. Family changes		

(5) DEV/SCHOOL PERFORMANCE

	13. Do you ever feel depressed & down?
	14. Have you ever thought of hurting yourself?
	15. What worries you? or makes you angry?
	16. Do you feel you will be successful?
	17. How do you feel about your performance?
	18. Do you own a gun? Has anyone ever tried to hurt you?
	19. Have you become sexually active?
	20. Do you use birth control? What kind(s)?
	21. Have you ever contracted an STD such as chlamydia, herpes?
	22. What does your family do together?
	23. Are you living away from home?
	24. Are you satisfied with job/school?

(2) PHYSICAL EXAM

	Nl	Ab
25. WT _____, HT _____		
26. BMI _____%		
27. HR _____		
28. BP _____/_____		
29. Skin		
30. HEENT ears, nose, throat		
31. Teeth		
32. Lungs		
33. Heart		
34. Breasts (males, gynecomastia, teach females BSE)		
35. Abdomen		
36. Genitalia		
37. Testicles (teach self exam)		
38. Pelvic (if sexually active) PAP smear		
39. Tanner Stage _____		
40. Musc/Skel (scoliosis)		
41. Neuro		
42. Extremities		
43. General hygiene		

(4) SCREENING

	Nl	Ab
45. If at risk, do:		
Vision		
Hearing		
PPD		
Hct/Hgb		
46. Hyperlipidemia risk assessment		
If abnormal, Lipid results _____		
47. If sexually active:		
Gonorrhea	Neg	Pos
Chlamydia	Neg	Pos
48. If at risk: HIV	Neg	Pos
Syphilis RPR/VDRL	Neg	Pos

(3) IMMUNIZATIONS GIVEN

	Y	N
44. Up to date? (HBV, MMR # 2, Td)		

(6) KEY ANTICIPATORY GUIDANCE

	49. Use seatbelts, follow speed limits		56. Recognize & deal with stress, S/S depression		61. If having sex, ask for exam, discuss birth control & safer sex
	50. Bike, motorcycle, ATV helmets, MGS		57. Limit fat/chol. intake; eat more grains, fruits & veg; adequate calcium/iron (females)		62. *Learn useful new skills (CPR...)
	51. Test smoke detectors/change batteries		58. Brush teeth, floss, see dentist		63. Become a community advocate
	52. Review job safety rules		59. *Educate yourself about birth control, STD's		64. Learn to become a health care consumer (i.e. insurance)
	53. Counseling avoiding tobacco, alcohol, smokeless tobacco		60. Sexuality education--safety, saying "no", abstinence, homosexuality		
	54. Discuss athletics, regular exercise				
	55. Sun exposure/sunscreen				

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN	EPSDT only: Child Needs Assistance for follow-up testing/treatment	Y	N

PHYSICIAN SIGNATURE: _____ **RTC in** _____ **months** **DATE:** ___/___/___

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